IDAHO DEPARTMENT OF
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August 6, 2009

Rusty Symons
Preferred Community Homes - Milliken
7091 West Emerald Street
Boise, ID 83704

Provider #13G053

Dear Mr. Symons:

On **August 4, 2009**, a complaint survey was conducted at Preferred Community Homes - Milliken. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004236

Allegation: Individuals leave the facility without staffs' knowledge because the facility is short staffed.

Findings: An unannounced onsite complaint investigation was conducted on 8/3/09 and 8/4/09. During that time, a review of the facility's elopement policy, incident reports, investigations, as-worked staffing schedules, observations, record review, and staff interviews were conducted with the following results:

During the entrance conference on 8/3/09 at 9:30 a.m., the Administrator stated there were six individuals residing in the facility. The Administrator stated two individuals required 1:1 arm's length supervision and four individuals required line of sight supervision. The Administrator reported two individuals were currently out of town, visiting family members. When asked, the Administrator stated four direct care staff were required for day and evening shifts and three staff were required for graveyard shifts.

The facility's as-worked staffing schedules, dated 7/09, were reviewed and showed there were no less than four direct care staff on the day and evening shifts and three direct care staff on the graveyard shifts.

The facility's incident reports were reviewed from 4/17/09 through 8/2/09. The reports showed there were a total of three incidents within the last two weeks (of the survey date) which involved two individuals leaving the facility without permission (elopement). Two incident reports documented the individuals left the facility but remained in staffs' line of sight during both incidents.

The third incident report, dated 7/31/09, showed an individual left the facility during graveyard shift (10:00 p.m. - 6:00 a.m.) without staff's knowledge. The 7/31/09 incident was in process of being investigated at the time of the survey. However, preliminary information showed three day shift staff arrived at approximately 6:00 a.m. The day staff person, assigned to the individual, did not visualize the person's skin and respirations. The second staff, the day shift lead worker, did not do so either. At approximately 7:45 a.m., a third day staff walked by the individual's bedroom and stated the individual's bed "did not look right." The preliminary information showed the individual's clothes, in the shape of a body, were found under the blanket on the individual's bed. The Administrator was notified and a search was conducted as per the facility's Elopement policy, dated 6/11/03. The individual was found at a local health club by facility staff around 9:30 a.m. on that same day. The individual was placed on 1:1 arm's length supervision upon returning to the facility.

The preliminary information showed the individual was thought to have left the facility on 7/31/09 at approximately 2:00 a.m. The preliminary information showed three graveyard staff completed 5 minute bed checks but did not conduct the required visual "flesh" checks of each individual.

Observations were conducted across all three shifts on 8/3/09 and 8/4/09, for a cumulative 2 hours 27 minutes. During that time, four individuals were noted to be in the facility. Three individuals were noted to be 1:1 arm's length supervision and one individual was noted to be in line of sight supervision.

Nine direct care staff (four day staff, two evening staff, and three graveyard staff) were interviewed during the course of the survey. When asked, all staff consistently identified the individuals' supervision requirements. Further, all staff consistently stated bed checks were conducted every five minutes and staff were required to look at the individual's skin, to ensure the person was actually present.

Three individuals' records were selected for review. Two of the individuals' records showed they had both recently left the facility without permission. Of those two records, one individual's record contained a program plan related to elopement and the second individual's record showed a program plan was in process of being developed.

The facility did fail to ensure staff completed thorough visual checks of an individual. This resulted in the individual leaving the facility without staffs' knowledge. However, once the individual was noted to be missing, the facility responded promptly and appropriately. While the incident occurred, it was not related to insufficient staff. The facility had taken steps to investigate and prevent future incidents, therefore, no deficiencies were cited.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

M. Williams

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MW/mlw